WOMEN'S REPRODUCTIVE HEALTH PROBLEMS IN RURAL NEPAL

WOMEN'S REHABILITATION CENTRE
NEPAL 1991

WOMEN'S HEALTH PROGRAMME

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Edited by : **Binayak Rajbhandari**, M.Sc., Ph.D.
Renu Rajbhandari, M.D., M.P.H.

Research Team : **Renu Rajbhandari**
Babu Ram Gautam
Nava Raj Raut
Binayak Rajbhandari

Computer : **Bina Pokharel**
Laxmi Acharya

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Cover Photo : Rural women who participate in focus group discussions at Salyan.

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Preface

Women's health has so far been a neglected issue in Nepal. Most often it is confused with the family planning and maternal / child health care. Women's health is a much broader concept which covers various factors and their impacts on social, economic, physical, mental and psychological aspects of women's health. The women's health concern starts with her birth and continues till death. The women's health concept is based on four ethical principles, viz. bodily integrity, womanhood or right to self-determination, equality and respect to diversity among women. An analysis of current health programmes and policies in Nepal revealed that appropriate and adequate importance has not been given to women's reproductive health concerns. It was in this background that WOREC has designed and implemented women's health programme in selected districts. This programme consists of such activities as research, training, education / advocacy, networking and service.

This report is an output of research work conducted by WOREC in 1997. This endeavour was made to gather and analyze the first hand information from the women about their perceptions, socio-cultural and religious traditions, problems and practices in relation to various diseases and/or environment which are responsible for women's health and subordinate status in the society. Probably this is the first research endeavour made for understanding the women's reproductive health issues in women's and gender perspectives in Nepal. This report provides information about the socio-demographic characteristics and the qualitative as well as quantitative information about the traditions, perceptions, problems and practices in regard

to menstruation, pregnancy and abortion, family planning, nutrition, various gynaecological aspects and health seeking behaviour of women in rural Nepal.

We hope that this report will be useful for the health workers, social workers, and wide circle of population groups both in Nepal and abroad.

We would like to express our sincere thanks to all women, girls and men who openly participated in focus group discussions, in-depth interviews and actively responded to the inquiries concerning their perceptions and problems about women's health issues. The supervisors, field workers and enumerators who facilitated the information gathering proceses are also highly acknowledged. At last but not the least Mrs. Bina Pokharel deserves special thanks for processing the very rough draft of the report and bringing to this shape.

30 October 1998

Research Team
WOREC

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SUMMARY

Nepal is a country with ethnic and cultural diversity and many religious- cultural traditions. But a number of social norms which are based on the religious-cultural traditions are found partially responsible for health problems of women. Specifically the social norms, values and traditions in relation to pregnancy, reproduction including son-bearing, miscarriage/abortion and the use of contraceptives have been the major factors of reproductive health problems of women in Nepal.

In rural Nepal, the key role of a woman is bearing of children, particularly sons. The women are compelled to have more children due to higher child mortality rates. Early and excessive childbearing weakens women, many of whom die or are chronically disabled from complications of pregnancy. Pregnancy is taken as a natural process and God's gift for which medical care is regarded as unnecessary.

In Nepalese society, particularly in rural areas, girls are married at very young ages to much older men. Adolescent pregnancy possesses grave health risks to the young mother. Relatively high proportion of teenage pregnancies has been reported to end in fetal loss, spontaneous abortion or infant death as well as other harmful consequences to the mother. Son preference, reflected in discrimination against female children in allocation of food and utilization of health services in a household can be taken as an explanation for excess female mortality in childhood. Reasons given for families preferring son to daughters include that sons maintain and extend the lineage, inherit property, provide support to parents in old age and farm the family land. Daughters on the other hand are regarded as a liability because they are married and go away. Therefore any investment on them for education, skill development etc. is thought to be a liability to the family. This concept which is more prevalent in rural societies has resulted in gender inequality in general and in the health care of girl children in particular.

This research was conducted to analyse the status of women's reproductive health in rural areas of Nepal for making effective strategic intervention planning.

This research covered four districts, viz. Udayapur, Nuwakot, Salyan and Baitadi. These districts were selected owing to their diverse ethnic structure, availability of health service and administrative and geographical reasons. WOREC has also been implementing various programmes in these districts. This research gathered qualitative and quantitative information employing standard methods of focus group discussion (FGD), in-depth interviews and survey. The summary of findings are presented below.

The primary causes of maternal mortality as reported by the respondents are sepsis, severe and chronic anaemia, hypertensive disorders and haemorrhage.

Owing to legal restriction to abortion, the women in rural areas use to perform abortion by untrained personnel in unsterile condition or even by inserting some objects into the uterus. Induced abortion or miscarriage has been reported to be extremely dangerous from the perspective of health and social consequences Various factors that caused spontaneous abortion included hard labour too soon after delivery, malnutrition during pregnancy as well as very young age of the pregnant girls. These perceptions were basically reported by women who belonged to such ethnic groups like Magar, Danuwar and Bishwakarma in targeted districts.

Many respondents agreed that contraception to space birth is important one. The husband's approval is reported to be critical for family planning acceptance. However, acceptance to family planning contraceptions varied among various ethnic groups. In some ethnic groups like Bishwakarma and Magar in Salyan district, vasectomy is found to be prohibited in religious ground. The justification given for this is that the vasectomised male can not worship the God and can not give "Pinda" to his ancestors etc. Most of the participants of FGDs reported that the FP contraceptives are not available in their villages. Most of the female participants reported that contraceptives like Dipo- provera and pills are bad for health. They therefore suggested that it is better to use the FP

measures by the husbands; on the contrary Tamang women suggested that it is better to use the contraceptives by females. Because their husbands have to carry on heavy loads and vasectomy may have bad impacts on their health.

Various health problems as reported by the respondents included infertility (10%), miscarriage (18%), uterine prolapse (24%), urinary problems (40%) and white discharge (52%).

Most of the respondents reported that the women with various health problems, e.g. miscarriage, hemorrhage, infertility etc. use to go to the local traditional healers (Dhami / Jhankri) because they are available in the community and provide service cheaper in the sense that they accept rice, chicken etc. which a woman can afford. Few women told that in few cases even their family members do not allow them to go to the traditional healers because the family head or husband regards it as useless and wastage of money. Only a few respondents reported that they were taken to the hospital. However, the male members of the family argued that women themselves do not want to go to the hospital and in that case the male members can not do any thing. While probing on this issue it was found that women do not want to go to the hospital because of various reasons: firstly, there are no female health workers at these places; secondly, the health workers are not regular and punctual; thirdly, the health facilities are quite far and practically inaccessible; and lastly medical care is costly and beyond the reach of common poor.

The subordinate status of women in Nepalese society has been found to limit the women's autonomy in decision making. It had limited their mobility and led to discrimination in health care utilisation. Lack of property right to women also led towards non-use of health services which results in high maternal mortality rates and to suffering of women from reproductive, gynecological and other health problems. More than four fifth of the women who had spontaneous or induced abortion did not get any treatment after the incidence.

I. INTRODUCTION

1.1. Background:

The issue of women's health is an acute problem among health and development workers all over the world. The Cairo conference (1994) and Beijing conference (1995) have stressed the need of research to address the issue of women's health problems employing holistic approach.

Nepal is a country with ethnic and cultural diversity and many religious cultural traditions. The religious-cultural tradition prevalent in Nepal has been primarily responsible for reproductive health problems of women. This tradition is more dominant in rural areas where religious-cultural norms, values and traditions in relation to pregnancy, reproduction, miscarriage or induced abortion, and the use of family planning (FP) contraceptives. Disparities among women of different caste, age, class, etc. are other factors of reproductive health problems of women.

The situation of women's reproductive health in Nepal is reported to be rather gloomy. It is now being increasingly realized that many of our development programmes fail to recognize and address problems from women's perspective. An analysis of existing health programmes in Nepal revealed that inadequate importance has been given to women's reproductive health concerns.

WOREC has been advocating that women's health concern starts with her birth and continues till death. In Nepalese society woman is viewed as a biological means of human reproduction. Various socio-cultural, socio - economic, religious- cultural and political factors have been influencing the women's health and relevant attitudes, traditions and behaviours. These factors are deeply rooted in our social structure where women have subordinate status resulted in low self- esteem.

Moreover, research works on women's health aspects have been scanty. In the absence of research effective strategic intervention planning can not be made.

It was in these backgrounds that this research work was carried out by WOREC in its targeted districts. The research work in Udayapur, Nuwakot and Salyan districts was conducted under women's health programme supported by the Ford Foundation, U.S.A. and in Baitadi it was conducted under the project "Integrated animation and women's health" which was supported by Caritas, Nepal.

1.2 Objectives:

The overall objective of this research was to analyse the status of women's reproductive health in rural areas of Nepal for making effective strategic intervention planning.

The specific objectives of this work were as follows:

- To assess the socio- demographic characteristics of women in rural areas;
- To analyse the traditions and perceptions of women in relation to menstrual problems;
- To assess the traditions, problems and practices in relation to pregnancy and abortion;
- To analyze the perception, traditions, problems and practices regarding family planning prevalent in rural areas;
- To find out nutritional status of rural women and relevant health problems;
- To find out common gynecological problems among rural women;
- To analyze the health service seeking behaviour of women and relevant traditional taboos prevalent in rural areas.

II. RESEARCH METHODOLOGY

This study was carried out during 1 May to 20 December 1997. The study covered four major regions of Nepal, viz., eastern, central, mid- western and far- western. The district selected for the study were Udayapur, Nuwakot, Salyan and Baitadi. The selection of four districts gives fair representation of the various geographical as well as politico -administrative regions. These districts were selected owing to their diverse ethnic structure, availability of health service and administrative and geographical reasons. WOREC has also been implementing various programmes in these districts.

2.1. Methods of Data Collection:

a. Qualitative data collection:

Two methods were applied to gather qualitative information from the respondents about women's reproductive health problems, perceptions, traditions & behaviours:

i. **Focus Group Discussion (FGD):** FGD was carried out by the supervisors / field workers and used to further explore the attitudes, behaviours, practices and traditions regarding the women's reproductive health issues. Participants of the FGD were selected randomly to represent various ethnic groups with varied socio – economic status. Male members were also selected for FGDs.

ii. **In-depth interviews (IDI)** of the women were conducted by trained women interviewers, who were familiar with the local conditions and could speak in local dialects. Women having specific health problems were selected for in-depth interviews. Randomly selected seven adolescent girls were also interviewed.

A group of researchers/supervisors were trained on the methods of data collection with special focus on interviewing women for their health issues. This training was carried out for 5 days by experts in the field of research and women's health. Annex-i provides the details of the research team.

All FGDs/IDIs were audio recorded as well as noted down by the field workers/supervisors. FGDs were facilitated by supervisors. Later on the information collected from FGDs/ IDIs was written down and analyzed. A total of 18 focus group discussions were conducted with 144 female and male participants representing various ethnic communities and age groups in targeted districts and IDIs were conducted with 10 women / adolescent girls.

b. Quantitative data collection:

Quantitative information was gathered by employing structured questionnaire (Annex– ii) during May – June, 1997. A total of 1000 individuals were interviewed in this manner. However, only 750 of the interview were considered valid for analysis.

A pretest of the questionnaire was carried out in the sub-urban areas of Kathmandu and necessary modification was incorporated. Suggestions from consultants were incorporated in relation to the complexity of the questionnaire and understanding of the rural women as per information available from respective district. So, the questionnaire was kept as simple as possible.

The questionnaire was in Nepali language. However, the researchers / supervisors were encouraged to use local dialect and expressions, phrases and words to gather more information. It also clarified many issues as perceived by the respondents.

2.2. Data Analysis:

A total of 1000 questionnaire were obtained from the research areas. However, only 750 questionnaires were found valid for the research analysis. Data of the survey were analyzed in the computer employing SPSS.

III. THE STUDY DISTRICTS

The four districts selected for this study included Udayapur, Nuwakot, Salyan and Baitadi (map-1). These districts have certain ethno-cultural diversity and geographical variations. Besides, the demographic/socio-economic characteristics, health facilities and health services provided in these areas considerably differ from one another as presented in district profiles. (annex-iii)

3.1 Udayapur

Udayapur district, which lies in between the Mahabharat and Churiya range of Hills, is representative of the Terai and lower hilly ecological region of Nepal. It has a total population of 221, 256 (CBS, 1995). The road infrastructure and comparatively well organized health service in this ecological region are some points in selecting this district. Besides, WOREC is working in this district for last 7 years. The traditional ethnic groups like Danuwar and Tharu comprise the predominant ethnic communities in this district, which are, at the same time, the disadvantaged population groups. Their culture and tradition greatly differ from those of other ethnic groups inhabiting in the hilly districts.

3.2. Nuwakot:

Nuwakot district lies in the central region of the country and fairly represents the hilly region. It has a total population of 245, 260 (CBS, 1995). Tamang community is the predominant ethnic group in this district. The cultural tradition of this community is very old. This district reflects various social, cultural and traditional aspects of the mountainous region and people of Nepal. WOREC has been working in the Tamang communities of Nuwakot for last 7 years.

3.3. Salyan:

Salyan district is located in the mid- western region of Nepal. It has a total population of around 181, 785 (CBS, 1995). This district comprises of mixed ethnicities or castes like Magar, Brahmin, Chhetri, Newar, Biswakarma and many others. However, Magar is the predominant ethnicity of this district. The diverse ethnic groups residing in this district fairly represent a blend of various cultures and tradition and beliefs regarding food habit, health behaviour and reproductive health problems. Located in the north of Mahabharat range this district represents the typical subtropical hilly area of Nepal.

3.4. Baitadi:

Baitadi district represents one of the remotest hilly districts of far-western Nepal. Its geographical location from the capital is far-away. It has a total population of 200, 716 (CBS, 1995). Various ethnic communities like Bhand, Chhetri, Brahman, Biswakarma etc. reside in this district. The health services, educational institutions and other infrastructures are poorly developed in this district. The social and cultural context is different than in other parts of the country.

Map 1. Districts covered by the research work

Women of different ethnic communities who provided information about their health status and perceptions.

Brahman/Chhetri Community

Danuwar Community

Magar Community

Tharu Community

Tamang Community

IV. FINDINGS

4.1. Socio-demographic Characteristics:

It is very important to have knowledge about the socio-demographic characteristics of the targeted population groups in order to understand and analyze their health issues properly in a holistic manner. This study therefore attempted to gather comprehensive socio-demographic information of the population groups in Udayapur, Nuwakot, Salyan and Baitadi districts.

The socio-demographic characteristics of the respondents is presented in Chart 1 & 2 and the Table - 1. Chart 1 shows the percentage distribution of respondents by age group. It is evident that about 73% of the respondents belonged to age group of 20-40 years, which is active reproductive age group.

Chart - 1
Distribution of respondents by age group

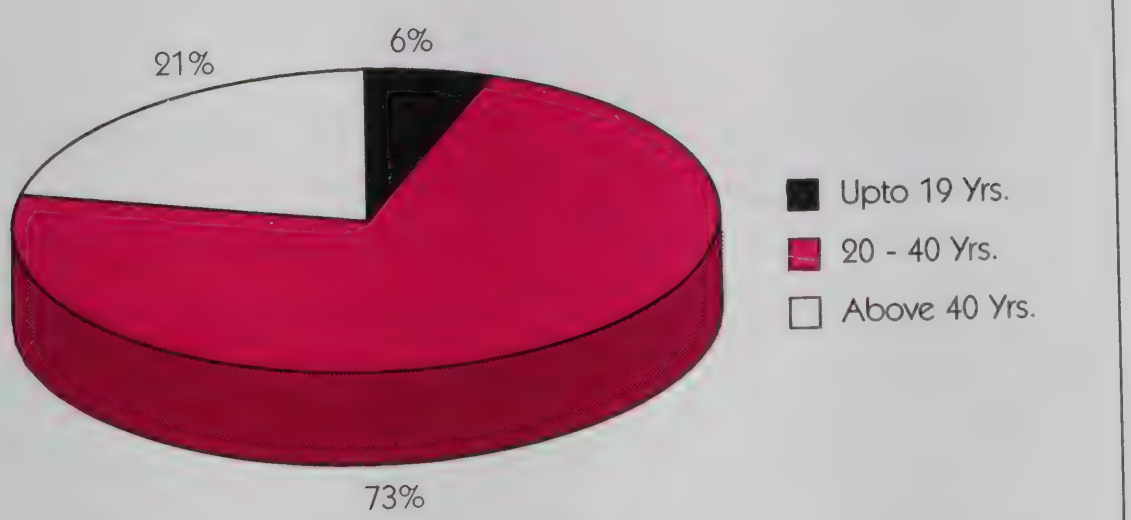
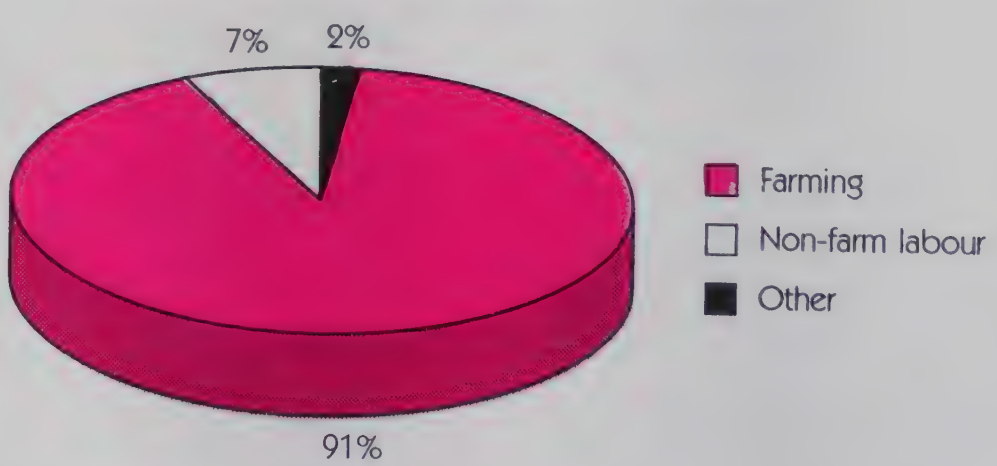


Table - 1
Marital status of the respondents

Marital Status	Number	%
Married for less than 3 years	219	29
Married for 3 to 5 years	151	20
Married for 6 – 10 years	258	35
Married for more than 10 years	115	15
Unmarried	7	1
Total	**750**	**100**

The in-depth interview basically focused on the married women (99 %). However, a total of seven unmarried girls (adolescents) were also interviewed. The data presented in Table-1 show the marital status of the respondents. Majority of the respondents were found married for the last 3 to 10 years.

Chart - 2
Occupation of the household heads



An overwhelming majority (91%) of the household heads of the respondents were engaged in farming. Other occupations of the household heads of the respondents included non- farm labour and service in the offices. (Chart - 2)

4.2. Menstruation

More than half of the respondents (57%) attained menarche by the age of 14 -16 years. Slightly more than a quarter (28%) of the respondents reported that their menstruation initiated at the age of 14 or below (Table - 2). These findings were also confirmed during the FGDs.

Table - 2
Respondent's age at the initiation of menstruation

S.N.	Age group	No. of respondents	%
1	Less than 10 years	10	1
2	10-12 years	24	3
3	12 – 14 years	173	23
4	14 – 16 years	427	57
5	16 – 18 years	88	12
6	18 – 20 years	20	3
7	20 and more years	8	1

Though most of the respondents were unaware of the concept of reproduction prior to the onset of menarche, they gradually learnt of the association between menses and reproduction (FGDs). Almost all of the participants of the focus group discussions, irrespective of locality or ethnicity, stated that they were fully unaware of the implications of menstruation until they attained it. Owing to the lack of prior knowledge among most of the respondents, their first reaction at the onset of menarche was usually negative. They reported that they were either shocked, puzzled or scared. A number of other studies have also indicated that there are misconceptions, ignorance and incomplete knowledge about the biological basis of menstruation

among young girls. In the USA, for example, sixth grade students who viewed themselves as "prepared" for menarche, had incomplete knowledge and possessed a variety of misconceptions (Koff and Rierdan, 1995).

Focus group discussions revealed that various socio-cultural norms and practices in relation to menstruation are prevalent in Nepal. A menstruating girl/woman is considered "impure" and "unholy" and is not allowed to participate in any religious ceremony or social functions. The rules are found to be more rigid among Brahman/Chhetri castes than in other communities like Danuwar, Tharu, Magar etc. The participants of FGDs stated that the religious-social norms and practices that restrict the girl/woman at onset of menstruation are as follows:

- She should not prey or worship the God;
- She should not attend any social occasions and religious festivals;
- She should maintain physical isolation for the first 3-4 days of menstrual periods;
- She should not fetch drinking water for the family and should not cook food,
- She should not touch milking cattle, fruit trees and male members of the family and community;
- She should not drink milk or eat other milk products.

In Nepal the girls with first menarche are kept isolated in dark rooms or even in cow-sheds (FGDs). They are not allowed to appear in front of any male member of the society and to be exposed to sun light. This tradition is yet prevalent in most of the districts and among so-called elite ethnic communities like Brahmin, Chhetri, Newar etc. even in the urban areas.

Menstrual disorder constitutes one of the major reproductive health problems among women (Bhatia and Cleland, 1995). More than a quarter of the respondents (30%) interviewed under this research reported that they were experiencing irregular menstrual cycle (Chart – 3). Among these respondents 16% reported that menstruation are frequent and occur before 28 days (Table - 3).

Chart - 3
Irregularity of menstrual cycle

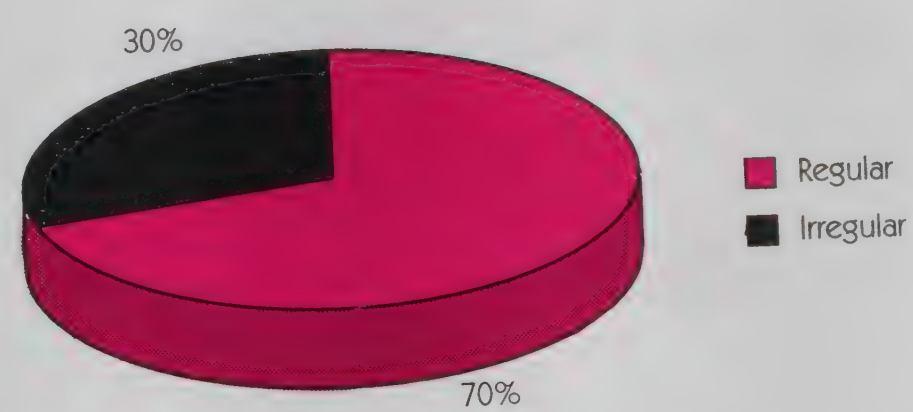


Table - 3
Frequency of the respondents by menstrual disorders

S.N.	Menstrual disorder	Number	%
1	Menses are frequent (occurs before 28 days)	123	54
2	Menstruation are rare (occurs longer than 35 days)	103	46

Menstruation is reported to cause various health problems associated with specific signs and symptoms. The major signs and symptoms identified during menstruation were excessive bleeding, backache, lower abdominal pain, blood clots etc. (Table 4). About one third of the respondents reported that they experienced excessive bleeding during menstruation. More than one fifth (22%) of the respondents experienced lower abdominal pain during menstruation and about a

quarter reported backache during menstruation. These results were found to be similar to those reported by Patel (1994) who conducted a study in tribal areas of Gujarat and revealed that excessive bleeding during menstruation is considered as a severe illness of women. The causes of this illness have been attributed to heavy work loads, weakness, consumption of "hot" foods, intercourse during menstruation and side – effects of tubectomy (Patel, 1994)

Table – 4
Symptoms encountered during menstruation*

S.N.	Symptoms	Number	%
1	Excessive bleeding	230	31
2	Backache	188	25
3	Lower abdominal pain	167	22
4	Blood Clots	101	14
5	Other	64	8
	Total	**750**	**100**

* multiple response

4.3. Pregnancy and Abortion

In most of the rural areas of Nepal girls are married in a very young age of 14 to 16 years to much older men (FGDs). Adolescent pregnancy possesses grave health risks to the young mother. Relatively high proportion of teenage pregnancies has been reported to end in fetal loss, induced abortion or infant death as well as other harmful consequences to the mother. Son preference, reflected in discrimination against female children in allocation of food and utilization of heath services in a household, can be taken as an explanation for excess female mortality in childhood. Reasons given

for families preferring son to daughters include that sons maintain and extend the lineage, inherit property, provide support to parents in old age and farm the family land. Daughters in the other hand are regarded as a liability because they marry early and have to leave the family. Therefore any investment on them for education, skill development etc. is thought to be a liability to the family (FGD). This concept prevalent in rural Nepal has resulted in gender inequality, in general and in the health care of girl children, in particular.

Among the respondents about 50% reported to have 3 to 4 or more children (Table - 5).

Table – 5
Number of living children

S.N.	Response	Number	%
1.	No children	103	14
2.	Only one child	118	16
3.	Two children	151	20
4.	Three children	160	21
5.	Four or more children	218	29
	Total	**750**	**100**

In the course of focus group discussions in different districts the participants stated that they were compelled to have more children owing to higher child mortality rate. Fifty percent of the respondents reported that two of their children died (Table - 6). Few respondents told that they had to continue reproducing until they gave birth to a son (FGDs). Early marriage and pregnancy cause various health problems to women. However, pregnancy is regarded as the gift of God (FGDs). Thus the religious-cultural tradition prevalent in Nepal can also be considered partially responsible for the reproductive health problems of women.

Table - 6
Number of children died

S.N.	Response	Number	%
1.	No death record	119	16
2.	One child died	238	32
3.	Two children died	379	50
4.	Three or more children died	142	2
	Total	**750**	**100**

Induced abortion has a very long history in this subcontinent, particularly in India and Nepal . The first reference to abortion occurs in the Atharva Veda (2000 - 800 BC). The Brihadyogalarinigini (1st century BC) is said to contain several contraceptive recipes, including a method for the occlusion of the cervix (Chandrasekar, 1974). The three Sanskrit medical classics, written respectively by Susruta, Charaka and Vaghbata I, which comprise the main body of knowledge of ancient Hindu medicine, deal with abortion and miscarriage amongst other reproductive issues (Ibid, p. 42). Susruta differentiates between "garabhapata" (spontaneous abortion) and "garabhasrava" (induced abortion). The former is classified as that which is up to four months, when only liquid is said to flow from the womb; the latter, when the limbs of the foetus have gained firmness or it is visible (Ibid, p. 43). The earliest reference to abortion is almost all condemnatory of the practice. Abortion on a fairly large scale, is stated to have existed during the Gupta period, the golden age of Hindu history. Even then, there were prescribed periods of gestation beyond which abortion was forbidden to be induced. The foetus had to be aborted before it gained firm shape or viability (Manekar, 1973) . However, abortion has not been legalised in Nepal.

Abortion or miscarriage has been reported to be extremely dangerous from the perspective of health and social consequences. In Nepal, particularly in rural areas, miscarriage has been doomed to suspicions of wrong doing or even witchcraft. The women who suffer from miscarriage are not provided rest, proper nutrition and care (FGDs). In Nepal abortion has been legally restricted . Therefore in rural areas women who did not want child used to perform abortion by untrained personnel in unsterile conditions or even by inserting some object into the uterus. Due to unavailability of proper health care facilities in the district level especially on women's health women use to follow the "culture" of keeping silence or trouble with themselves. A few women even die due to this and it has not been reported any where else. Termination of pregnancy is an important maternal health issue, given both the scale of numbers of women in need, and the dire consequences of mishandling. A considerable number of maternal deaths occur due to unsafe abortion. These situations have resulted in very harmful impacts to the women's reproductive health. Owing to the poor registration of vital statistics, however, the maternal mortality figures in Nepal are known to be grossly underestimated.

Table - 7

Frequency of respondents by month of miscarriage/abortion

S.N.	Month of abortion	Number	%
1.	No miscarriage / abortion	613	82
2.	Had miscarriage / abortion	137	18
	a) Less than 6 months	104	76
	b) Six or more months	33	24

In the course of in-depth interviews 18% of the respondents reported that they had undergone miscarriage and abortion (Table - 7). Out of these respondents 76% had miscarriage of less than 6 months foetus (second trimester). Miscarriage or induced abortion at any period of

gestation exposes women to some risk, which varies enormously depending upon the circumstances of the woman. Data from all over the world indicate that second trimester abortion is more hazardous than first trimester. (Henshaw, 1990). The findings of this research revealed that majority of the women having miscarriage or induced abortion during second trimester were exposed to high risk.

Table - 8
Willingness to carry out abortion
(N = 137)

S.N.	Response	Number	%
1.	Wanted to get aborted	23	17
2.	Did not want to get aborted	114	83

Twenty three out of 137 women who had experienced abortion/ miscarriage did not want to have the children and wished to get aborted but the rest (83%) wanted the foetus to survive (table 8). It is thus evident that most of the abortion were spontaneous. Various factors that caused spontaneous abortion included hard labour and malnutrition during pregnancy as well as very young age of the pregnant girls (FGD). These perceptions were basically reported by women who belonged to such ethnic groups like Magar, Danuwar and Bishwakarma in the targeted districts.

Table 9
Place where miscarriage /abortion occurred
(N = 137)

S.N.	Place	Number	%
1.	In the village (house)	118	86
2.	In the health institution	19	14

Most of the respondents (86%) who had experienced abortion / miscarriage, had it in the village / house while only 14% of them had induced abortion in some health institution (Table 9).

4.4. Family Planning

Most of the respondents agreed that contraception to space birth is important one. The husband's approval was, however, reported to be critical for using family planning contraceptives. Acceptance to family planning contraceptives varied among various ethnic groups. In some ethnic groups like Bishwakarma and Magar in Salyan district vasectomy has been prohibited in religious ground. The justification given for this is that the vasectomised male can not worship the God and can not give "Pinda" (sacred offering) to his ancestors etc. Most of the participants of FGDs reported that the FP contraceptives are not available in their villages. Most of the female participants stated that such contraceptives as Dipo-provera and pills are bad for health. This finding was also reconfirmed during focus group discussions: the women expressed the concern that they reduced the breast size and volume of milk; caused pain in the vagina. One respondent told that she had vaginal bleeding for 18 months with profound weakness, vision and hearing loss. Some respondents reported that the bad effects included black spots on face, menstrual disorders etc. Regarding the preferences of contraceptive for male or female, there is difference of opinion among various communities. Ethnic groups like Tharu, Danuwar, Brahman and Chhetri suggested that it is better to use the contraceptives by the husbands. Contrary to this Tamang women suggested that it is better to use contraceptives by the women. They argued that the men have to carry heavy loads on back and therefore contraceptives would have negative effect on their health (FGDs).

Only about one sixth of the respondents (16%) used some form of contraceptives (Table - 10). It showed that most of the women of

active reproductive age group have not been using contraceptives. The reasons behind not using contraceptives were feeling of physical and mental weaknesses as well as some other diseases among most of female population groups in rural areas. In the course of FGD, it was also learnt that pregnancy is regarded as a gift of God. That is why the contraceptives for preventing pregnancy are not usually used.

Table - 10
Frequency of Family Planning Contraceptive Users
(N = 750)

S.N.	Response	Number	%
1.	Do not use contraceptives	492	66
2.	Use some form of contraceptives	123	16
3.	No response (have no idea about contraceptives)	135	18

Majority of the contraceptive users obtained contraceptives from health posts (59%) and NGOs like WOREC (40%). Only about one percent of the contraceptive users reported that they used to obtain contraceptives from the social marketing (Table - 11).

Only 18% of the respondents mentioned that they have information about the contraceptives. Majority of these respondents (82%) reported that they obtained information about contraceptives from such organizations as health posts / hospitals or NGOs. The rest 28 % of the respondents told that they obtained information about family planning contraceptives from the media of mass communication like radio / TV or news papers (Table - 12). It should be noted that the number of women using contraceptives was less than those who claimed to have information about the FP contraceptives (table 11 & 12).

Among the contraceptive users 39 respondents (32%) reported that they had discontinued using them. Responding to the queries regarding the reasons for discontinuing the use of contraceptives 26% of the respondents of this group told that they are not available regularly in their locality while the rest (74%) discontinued it owing to bad effects (Table –13). The respondents reported about the bad effects of depoprovera. In the course of FGDs also similar responses were obtained from the participants irrespective of locality and ethnicity.

Table - 11
Sources of Contraceptives
(N = 750)

S.N.	Response	Number	%
1.	Non-user	627	84
2.	Users of contraceptives:	123	16
	• Health posts	72	59
	• NGO clinic (WOREC)	49	40
	• Social marketing	2	1

Table - 12
Sources of Information on Contraceptives
(N = 137)

S.N.	Source of information	Number	%
1	Health post/ hospital	29	21
2	Health worker (NGO)	70	51
3	Others (Radio/TV/Papers)	38	28
	Total	**137**	**100**

Table - 13
Reasons for discontinuing the use of contraceptives
(N = 39)

S.N.	Reasons	Number	%
1.	Contraceptives are not available regularly	10	26
2.	Bad effect on health	29	74

4.5. Nutrition

The food situation in targeted districts is poor (annex-iii). Malnutrition has been one of the major factors causing women's reproductive health problems. Weakness is the major complaint of rural women. It has been identified involving either protein - malnutrition or specific deficiencies such as iron - deficiency anaemia. The severe and chronic iron - deficiency anaemia has been found to elevate the risk of miscarriage, prematurity, parental morbidity and even death of the mother. Various ethno-cultural and traditional beliefs prohibiting consumption of iron-rich or protein -rich food to the pregnant and child bearing women have been found responsible for these health problems of women. The nutritional deprivation of young / adult women affects not only their own health but also the health of the foetus and nursing child. Women were forced to do excessive labour during pregnancy or child bearing. This type of forced labour together with anaemia was reported to be one of the causes of maternal death and /or miscarriage (FGD).

Various signs and symptoms of anaemia as perceived by the respondents were as presented in table - 14. Frequency of these signs and symptoms varied among ethnic groups and locality. The major signs and symptoms which were reported by more than 50% of the respondents included feeling of giddiness, shortness of breath and extreme tiredness (Table - 14). The respondents reported one or more signs and symptoms.

Table - 14
Signs and symptoms of anaemia as stated by the respondent women

S.N.	Symptoms of anaemia	Number	%
1	Extreme tiredness	479	56
2	Shortness of breath	439	59
3	Feeling of giddiness	505	67
4	Disturbed sleep	179	24
5	Whitish tongue, nail, eyelids	320	43

Overwhelming majority of the respondents stated that their basic meals are carbohydrate rich (Table - 15). This fact indicated that most of the population in rural Nepal use to have unbalanced meal.

Table - 15
Food consumption in the morning (brunch) and evening (dinner)

S.N.	Response	Brunch	%	Dinner	%
1.	Carbohydrate rich food	614	82	577	77
2.	"Balanced" diet	12	2	14	2
3.	Poor (Low quality) food	124	16	159	21
	Total	750	100	750	100

NOTE: The major meals are taken two times in a day: at about 9-10 am & 6-7 pm.

4.6. Gynaecological Problems

• Infertility

In the course of this research it was identified that the problem of infertility was prevalent among 10% of the interviewed community members (table - 16). However, most of these respondents (79%) had not undergone medical examination for infertility. They have not undergone this examination because these facilities were not available to the targeted population groups.

In the focus group discussions conducted in Udayapur, Nuwakot, Salyan and Baitadi districts women explained that they completely rely on traditional healers or Tantrik for the identification and treatment of the problems of infertility (FGD).

Table - 16
Reported infertility among women
(N = 750)

S.N.	Response	Number	%
1.	Does not have this problem	672	90
2.	Has this problem:	78	10
	• Medical examination done	16	21
	• Medical examination not done	62	79
	• Medical exam easily available	28	36
	• Medical exam not easy	50	64

- **Uterine Prolapse**

Uterine prolapse is commonly called as *"aang khasne"* in Nepali. Out of the total respondents above 23% reported having the problem of uterine prolapse (Table - 17). However, the degree of uterine prolapse varied from first degree (76%) to third degree (11%) among the respondents having this problem (Table - 18).

Table - 17
Prevalence of prolapse of uterus as reported by the respondents
(N = 750)

S.N.	Response	Number	%
1.	No problem of prolapse of uterus	572	76
2.	Has prolapse of uterus	178	24
	Total	**750**	**100**

Table - 18
Frequency of the degree of prolapse of uterus
(N=750)

S.N.	Response	Number	%
1.	Prolapse a little (1st degree)	137	76
2.	Prolapse more than 50% (2nd degree)	23	13
3.	Whole uterus proplapsed (3rd degree)	18	11

The frequency of uterine prolapse among the respondents was found to vary in relation to the number of delivery (Table - 19). It was stated that majority of the women with uterine prolapse have been experiencing it after the birth of the first or the second child 42% and 31%, respectively.

It might be speculated that heavy physical work immediately after delivery has been responsible for uterine prolapse. Only about 1% of the sufferers from uterine prolapse stated that they have been experiencing it after the birth of the fifth child.

Table - 19
Frequency of uterine prolapse in relation to the number of delivery
(N = 178)

S.N.	Response	Number	%
1.	After the birth of first child	74	42
2.	After the birth of the second child	55	31
3.	After the birth of the third child	24	13
4.	After the birth of the fourth child	23	13
5.	After the birth of the fifth child	2	1

• Urinary Infections

Women and adolescent girls expressed urinary problems as *"pisab polne", "pisab rokine"* and *"pisab chuhine"* in Nepali (FGD). These problems included inflammation, infections and incontinence (urgency and stress incontinence).

Out of the total respondents 297 women reported that they were feeling burning sensation during urination. One hundred twenty five respondents (16%) stated that they have urinary problems (urgency of urination or stress incontinence) lasting for more than six months (Table - 20). Many women commonly suffer from stress incontinence especially after childbirth. However, it is also experienced by post-menopausal women (Sodhini, 1997).

Table - 20
Distribution of respondents with urinary problems.
(N = 750)

S.N.	Response	Number	%
1.	Feel burning sensation during urination	297	39
2.	Urinary problems lasting for more than 6 months	125	16
3.	Does not have the problem	328	45

- **Vaginal Discharge**

Vaginal infections are one of the most common complaints expressed by women. Vaginal discharge other than blood is called *"seto pani"* in Nepal i.e. white discharge.

More than 50 % of the respondents reported that they experienced white vaginal discharge (Table - 21). The quality of white discharge was reported to vary (Table - 22). The qualitative variation of white discharge included watery (48%), thick (40%), yellowish (7%) in colour or bad smelling (6%). The qualitative variation of white discharge should be taken as an indication of vaginal infection. Sodhini (1997) has pointed out that when the delicate balance of vaginal bacteria is disturbed, the harmful organisms present in the vagina multiply out of all proportions. These harmful organisms may secrete large amount of waste which irritate the vaginal walls and cause infection. The discharge could develop a foul smell, and change in colour, consistency and quantity causing mild or severe itching and burning of vulva, pain during intercourse, chafing of thighs and, occasionally, frequent urination.

Table - 21
Frequency of the respondents having white discharge

S.N.	Response	Number	%
1.	Does not have white discharge	286	38
2.	Have white discharge	386	52
3.	Have no idea about white discharge	78	10

Table - 22
Frequency of the quality of white discharge
(N = 386)

S.N.	Response	Number	%
1.	Thick discharge	154	40
2.	Watery discharge	184	48
3.	Yellowish discharge	26	7
4.	Bad smelling discharge	22	5

- **Lower Abdominal Pain:**

Lower abdominal pain is termed as *"tallo pet dukhne" or "sano bhundi dukhne" in Nepali. It is a common complaint among women.*

Out of the total respondents 63% reported that they had experienced lower abdominal pain (Table - 23). The characteristics of lower abdominal pain, however, was reported to vary among the respondents. Majority of the women stated that they experienced regular pain during menstruation or almost always. Thirteen per cent of those women reported that they experienced lower abdominal pain during intercourse (Table - 24).

Table - 23
Frequency of complaints of lower abdominal pain

S.N.	Response	Number	%
1.	# of respondents with lower abdominal pain	474	63
2.	# of respondents not having this problem	249	33
3.	Have no idea about it	27	4

Table - 24
Characteristics of lower abdominal pain
(N= 474)

S.N.	Characteristics	Number	%
1.	Regular pain	128	27
2.	Experience pain during sexual intercourse	62	13
3.	Experience pain during menstruation	207	44
4.	Pain only sometimes	77	16

• Urethral Discharge

About 40% of the women reported that they experienced pus like discharge from the urethral opening (Table - 25). This provides basis for suspecting high prevalence of sexually transmitted diseases among the women. However, only clinical investigation would confirm the prevalence of STDs among the women in rural areas.

Table - 25
Experience of pus like discharge while urinating
(N = 750)

S.N.	Response	Number	%
1.	No problem as such	453	60
2.	Pus like discharge while urinating	297	40

4.7. Health Service Seeking Behaviour:

Utilization of health services is a complex behavioural phenomenon in Nepalese society and has been found to be very low (FGD). It is affected by many factors such as availability, distance, costs, quality of care, social structure and health beliefs. Many of these factors are found interrelated with gender inequality reflected in women's subordinate status in the society. Women's status has been affecting their access to health services. Most of the female respondents reported that they can not themselves decide to seek health service. The decision is made by their husbands or senior members of the household. Costs and distance considerations are also interrelated with this kind of gender inequality. It was found that quite a large number of rural women do not use to go to the hospital / health centre.

Fairly a higher number of married women (58% of the women experiencing abortion / miscarriage) fell very sick after miscarriage (table - 26) and more than four fifth of the married women who had experienced abortion or miscarriage did not seek service (table - 27).

Table - 26
Sickness after having abortion/miscarriage
(N = 750)

S.N.	Response	Number	%
1.	No abortion / miscarriage	613	82
2.	Had abortion/miscarriage	137	18
	• Fell very sick after abortion	80	58
	• Did not fall very sick after having abortion/miscarriage	57	42

Table - 27
Seeking of services after miscarriage/abortion
(N = 750)

S.N.	Response	Number	%
1.	No miscarriage / abortion	613	82
2.	Had abortion/miscarriage	137	18
	• Got treatment after miscarriage/abortion	23	17
	• Did not seek service after miscarriage/abortion	114	83

Sixty eight percent of the respondents experiencing uterine prolapse did not get any treatment while 13% tried some herbal medicine (table - 28). Nineteen percent of the women with the problem of uterine prolapse have been ignoring the problem. Focus group discussions revealed that women go to the traditional healers *(Dhami/ Jhankri)* for the treatment after miscarriage/abortion. The reasons behind getting their services is their all time availability in village and they accept anything like rice, chicken, wheat, flour etc. which the

women can afford as a fee. The health institutions do not have health workers often; are located far off and the women do not have time to go there or do not have cash for payment.

Table - 28
Frequency of treatment sought for prolapse of uterus
(N = 178)

S.N.	Response	Number	%
1.	Tried some treatment (herbal)	23	13
2.	Did not get any treatment	121	68
3.	Have not cared for it	34	19

Out of the total respondents (297) having burning sensation during urination (cf. table 20) only 257 women responded to the queries made for the service seeking behavior. Out of these above 2/3 did not seek treatment for the urinary problems. Only 28% of these respondents sought treatment evidently owing to severe burning sensation during urination. Nearly 54% of these respondents consulted doctor while the rest went to the traditional healer or used herbs (Table - 29).

Table - 29
Frequency of service seeking women with urinary problem
(N = 257)

S.N.	Response	Number	%
1.	Did not seek treatment	185	72
2.	Sought treatment for urinary problem	72	28
	those who sought treatment:x		
	• Consulted doctor	39	54
	• Consulted traditional healers/used herbs	33	46

V. Conclusions and suggestions

5.1. Conclusions:

This research was carried out to reflect the prevalence of women's reproductive health problems in rural Nepal in response to the dire need. Four districts of Nepal from the Eastern, Central, Mid Western and Far Western regions were included in the study, representing a cross section of the society. The findings which reflected the reproductive health status of women in rural Nepal led to make the following conclusions:

- A majority of the menarche (first menstruation) was attained at the age of 14-16 years. 85% of the women had menarche by the age of 16.
- Menstruation was not clearly known to the women before puberty. The nature and implications of menstruation was known to the women only after they attained it.
- About a third (30%) of the women stated that they had irregular menstrual cycle.
- An overwhelming majority of the women stated that they had some or other symptoms (like backache, lower abdominal pain, blood clots etc.) encountered during menstruation.
- An overwhelming majority (84%) of the women stated that they had experienced death of their children after normal delivery. Half of the respondents (52%) had experienced death of two or more children.
- About one fifth (18%) of women had experienced miscarriage or undergone abortion during their life time. More than 75% had undergone abortion / miscarriage of less than 6 months foetus.

- Of those, who had abortion / miscarriage, majority (83%) did not want to have miscarriage/ abortion. However, a few wanted that the fetus be expelled.
- 86 % of the miscarriage/ abortion occurred at home in the village without any care taker to look after. Only a sixth (17%) got some treatment after miscarriage/ abortion.
- About a sixth (16%) of the women stated that they were using contraceptives through health workers and NGO.
- More than a half (59%) of the women expressed symptoms related with anaemia.
- "Balanced diet" was consumed by only 2%, 21% of the respondents had poor quality food, and 77% of the women consumed carbohydrate rich food. This fact indicated that most of the population in rural Nepal use to have unbalanced meal.
- 10% of women had the problem of infertility. But only 21% of those women had attended for medical examination.
- About a fourth (24%) of the women had the problem of prolapse of uterus. Prolapse of uterus was reported even after birth of the first child. Two third of the women did not seek medical help for their uterine prolapse. Heavy physical work too soon after delivery and multiple pregnancies were reported to be the common reasons for uterine prolapse.
- About 40% of the women had urinary problems with pus like discharge and burning sensation during urination. However, only a fourth of them (28%) sought medical treatment.
- More than a half (52%) of the women had vaginal discharge. The qualitative variation of vaginal discharge revealed higher percentage of vaginal infection prevalent among the respondents.
- Out of the total respondents 33% had lower abdominal pain and 40% had pus like urethral discharge. These findings provide

basis for suspecting high prevalence of sexually transmitted diseases among the women.

- Utilization of health services by the women was found to be very limited and affected by many factors such as availability, distance, costs, quality of care, social structure and health beliefs. Many of these factors were found interrelated with gender inquality and discriminations reflected in women's subordinate status in society and lack of respect to diversity among women.

5.2. Suggestions:

This research clearly shows the low reproductive health status of rural women in Nepal. Many reproductive health problems are not considered seriously or are overlooked. Issues like abortion / miscarriage, uterine prolapse, vaginal discharge and health care or service utilization are not given proper attention. In this light, the following suggestions are made.

- The reproductive health issues should be addressed adequately and equitably to all women, which could be done through appropriate information, education and communication strategies and euitably accessible health services and reproductive rights to all women.
- Women should be encouraged to seek medical help whenever they have some problems. Priority should be given to the reproductive health issues in each and every health institution for providing feasible and appropriate treatment.
- More research is needed to compare the community based data with the clinical data. The high prevalence of reproductive health problems among rural women requires more detailed study to identify avenues to address them adequately.
- Activities to ensure empowerment of the women and involvement of men in this respect should be carried out.

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Annex i

Research Team, Consultants and Review Team

A. The Research Team

Dr. Renu Rajbhandari

Mr. Babu Ram Gautam

Mr. Nava Raj Raut

Dr. Binayak Rajbhandari (Technical Advisor)

B. Consultants

Dr. Yogendra Bhakta Pradhananga, IOM /TU, Kathmandu

Dr. Kedar Baral, Phect, Kathmandu

C. The Review Team

Prof. Dr. Sanu Maiya Dali,
Sarbanga Nursing Home, Lalitpur, Nepal

Prof. Dr. Kailash Pyakuryal,
Central Dept. of Anthropology & Sociology,
Tribhuvan University, Kathmandu

Dr. Yogendra Bhakta Pradhananga
Community Health Dept.
Institute of Medicine
Tribhuvan University, Kathmandu, Nepal

Dr. Bal Krishna Suvedi
Senior Medical Officer
National Centre for STD/ AIDS Control

Dr. Swaraj Rajbhandari
Chief, Gynae. Obs., Dept.
Kathmandu Model Hospital/ Phect
Kathrmandu, Nepal

Annex-ii

WOREC

Questionnaire for survey on Women's Reproductive Health Status

Name of the staff taking interview

_____

Date: _____

Name: _____

Address: VDC _____ Ward No. _____

_____ District : _____

A: Problems associated with menstruation:

1. What was your age when menstruation started ?

   Age .....

2. Is your menstrual cycle ?

   ☐ regular ☐ irregular

   If irregular then in how many days :

   ☐ occurs before 28 days

   ☐ occurs longer than 28 days

3. What happens during menstrual period ?

   ☐ excessive bleeding ☐ lower abdominal pain

   ☐ backache ☐ blood clots

B. Questions for women of child bearing age:

1. What is the age of your youngest child ?

2. Number of your children now surviving

3. Have you lost any of your babies ?

☐ yes ☐ no

if yes, how many ?

☐ one ☐ two ☐ three or more

what was the reason:

☐ miscarriage ☐ born dead

☐ died immediately after birth

4. If miscarried then in which month

☐ less than 6 months ☐ six or more months

5. Did you consult medical doctor or took any medicine after miscarries ?

☐ yes ☐ no

6. Was the miscarriage / abortion as per your will

☐ yes ☐ no

If yes, where and how did you do it ?

☐ in the village ☐ in health institutions

7. Did you fall sick after miscarriage / abortion?

☐ yes ☐ no

8. If yes, where did you go for treatment ?

☐ health centre ☐ traditional healer

☐ ignored

9. What are the means you have used for maintaining age gap between children :

☐ nothing ☐ FP contraceptives

10. Where did you get the contraceptives from ?

☐ health post ☐ WOREC clinic

☐ social market

11. Did you have knowledge about the contraceptive you used ?

☐ yes ☐ no

12. Where did you get the information about the contraceptive

☐ Health post ☐ Health worker of NGO

☐ Others (radio/TV/papers)

13. What were the reasons of discontinuing the use of contraceptive?

☐ unavailability ☐ bad effects on health

☐ others, if any

C. Questions for the women with the problem of infertility:

1. How long have you been married ?
years .....

2. What is your husband's profession?

3. Had you ever gone for check up when you could not have children ?

☐ yes ☐ no

4. If underwent check up,
   Was it easy to undergo check-up ?
   ☐ yes ☐ no

D. Anaemia:

What are your experiences ?

1. Extreme tiredness	☐ yes	☐ no
2. Shortness of breath	☐ yes	☐ no
3. Feeling of giddiness	☐ yes	☐ no
4. Disturbed sleep	☐ yes	☐ no
5. Whitish tongue, nail and eyelids	☐ yes	☐ no

Food habit:

1. What are the usual items in your brunch _____
   ☐ carbohydrate rich ☐ balanced diet
   ☐ poor diet

2. What are the usual items in your dinner _____
   ☐ carbohydrate rich ☐ balanced diet
   ☐ poor diet

E. Prolapse of uterus:

1. How frequently do you wash the clothes ?

2. What is your usual position while washing the clothes:
   ☐ sitting by folding legs
   ☐ sitting without folding legs

3. What was the reason that you do not sit by folding legs?

.....

4. Do you feel that some thing is coming out of the urethral opening ?

☐ yes ☐ no

5. if yes,

☐ do you just feel it (1st degree)

☐ does most of the uterus come out (2nd degree)

☐ does the whole uterus come out (3rd degree)

6. How long have you been experiencing the problem?

7. Have you done some thing to retain prolapse of uterus ?

☐ yes ☐ no

if yes,

☐ went to hospital

☐ tried some herbs ☐ did not care for it

if no,

☐ could not get treatment ☐ did not care for it

8. Prolapse of uterus has been a problem for you after the birth of

☐ first child ☐ second child

☐ third child ☐ fourth child

☐ fifth child

9. How frequently do you urinate:

☐ very frequently ☐ not frequently

10. If very frequently then:

☐ in few minutes ☐ in one hour

11. Does urine drop out continuously :

☐ yes ☐ no

12. Do you feel burning sensation while urinating ?

☐ yes ☐ no

13. How long have you the urinary problem

☐ less than 6 months

☐ more than 6 months

14. Have you done something to check it ?

☐ yes ☐ no

if yes,

☐ consulted doctor ☐ consulted traditional healer

15. Have you remarked any white discharge from vagina?

☐ yes ☐ no

☐ not remarked

16. If yes, then whether it is:

a. thick ☐ yes ☐ no

b. watery ☐ yes ☐ no

c. foul smelling ☐ yes ☐ no

d. yellowish in colour ☐ yes ☐ no

17. Do you have lower abdominal pain:

☐ yes ☐ no ☐ have no idea

18. If yes, when:

☐ always (regular pain)

☐ during sexual intercourse

☐ during menstrual period

☐ only sometimes

19. Is there any pus like discharge from urethral opening :

☐ yes ☐ no

Annex iii

1. Demography / Socio-Economic Characteristics (CBS, 1993)

Particular	Udayapur	Nuwakot	Salyan	Baitadi
POPULATION				
Total	221,256	245260	181,785	200,716
Male	109,704	122,531	90,168	96,345
Female	111,552	122,729	91,617	104,361
CHILDREN UNDER 5 YRS.				
Total	33,937	37,269	30,160	32,243
Male	17,080	18,934	15,204	16,067
Female	16,857	18,329	14,956	16,176
POPULATION 60+				
Total	11,998	16,244	6,948	13,289
Male	5,843	8,354	3,651	6,393
Female	6,145	7,890	3,297	5,896
SEX RATIO (%)	98	99	98	92
DENSITY OF POPULATION (Per Sq. Km.)	107.25	218,78	124.33	132.14
POPULATION GROWTH During the Decade (1981-1991)	3.25	1.89	1.78	1.14

Particular	Udayapur	Nuwakot	Salyan	Baitadi
% LITERACY RATE				
Total	38.2	31.6	29 8	35.7
Male	55.2	45.4	47 5	60.0
Female	21.5	18.0	12.5	13.5
INFANT MORTALITY				
Rate Per 1000	74 (76)	94 (96)	134 (142)	138 (146)
LIFE EXPECTANCY	60 and upto 65	55 and upto 60	50 and upto 55	Under 50
FOOD SITUATION	very poor	poor	poor	very poor

2. Health Personnel and Facilities

Particular	Udayapur	Nuwakot	Salyan	Baitadi
Doctor Population Ratio	1:55.314	1:40,876.66	1:45,446.25	1:50,179
VHW Population Ratio	1:4,707.57	1:3714.19	1:3,876.76	1:2,951.70
Hospital (HMG)	1	1	1	1
Health Centre	1	1	1	1
PHC	1	1	1	1
Ayurvedic Aushadhalaya	2	5	2	2
Health Post	9	10	10	11
Sub Health Post	25	31	26	33

3. Percentage Achieved to Proposed Target in Family Planning Services

Particular	Udayapur	Nuwakot	Salyan	Baitadi
CPR (Weighted average)	13.41%	16.49%	12.47%	7.18%
Condoms	0.47%	0.94%	1.63%	0.83%
Pills	0.77%	0.37%	0.90%	0.59%
Depo Provera	1.03%	2.15%	1.69%	0.60%
IUD	0.05%	0.01%	0.00%	0.00%
Norplant	0.00%	0.06%	0.00%	0.00%
Sterilisation	10.83	12.95%	8.25%	5.15%

4. Percentage Achieved to Proposed Target in Immunization

Particular	Udayapur	Nuwakot	Salyan	Baitadi
DPT	4,949 (60%)	5,797(64.8%)	5,129(74.9%)	2,016(29%)
BCG	5,252(63.6%)	6,722(75.1%)	5,235(76.4%)	3,094(44.8%)
Polio	4,975(60.3%)	5,805(64.9%)	5,129(74.9%)	2,016(29.2%)
Measles	4,981(60.4%)	6,850(76.5%)	6,398(93.4%)	4,330(62.6%)

WOREC PUBLICATION

1.	Girl Trafficking		Price N
	A. Flip Chart "Chelibeti Deha Byapar:	–	2500
	B. VIDEO Film "Bedana Ra Mukti"	–	1200
	C. Book "Girl Trafficking"	–	100
	D. Present Statues of Nepalese Prostitutes at Bombay	–	15
	E. Journal "Cheliko Byatha"	–	30
2.	STDS'/AIDS and Family Planning/Nutrition		
	A. Leaflet on STDS'	–	25
	B. Wall Chart on STDS'	–	6
	C. Wall Chart on AIDS (Suraksha Kawach)	–	7
	D. Poster on AIDS	–	7
	E. Poster on AIDS (New)	–	9
	F. Book "AIDS Education" Series No	–	24
	G. Leaflet on AIDS	–	3
	H. Pictorial Book (AIDS)	–	20
	I. Book "Introduction to AIDS	–	20
	J. Book on "Family Planning and Nutrition"	–	20
	K. AIDS Manual	–	15
	L. Flip Chart on STD	–	300
3.	Community Mediation		
	A. Guide Book for Mediation	–	30
	B. Pictorial book "Chetana"	–	25
	C. Girl Trafficking : Legal Aspect	–	25
	D. News Letter on Mediation	–	6
4.	Non–Formal Education		
	A. Diyo- 1	–	25
	B. Diyo- 2	–	35